Discharge Protocols for
Community Services Boards and State Mental Health Facilities

The attached protocols are designed to provide consistent direction and coordination of those activities required of state facilities and Community Services Boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the *Code of Virginia* or the Continuity of Care Procedures in the Community Services Performance Contract. In these protocols, the term CSB includes local government departments with policy-advisory CSBs, established pursuant to §37.1-195 of the *Code of Virginia*, and behavioral health authorities, established pursuant to §37.1-242 et seq. of the *Code of Virginia*.

DEFINITIONS

The following words and terms, when used in these protocols, shall have the following meanings, unless the context clearly indicates otherwise.

Acute Admissions or Acute Care Services means services that provide intensive short term psychiatric treatment in state mental health facilities for a period of less than 30 days after admission.

Case Management CSB means a citizen board established pursuant to 37.1-195 of the *Code of Virginia* that serves the area in which an adult resides or in which a minor's parent, guardian or legally authorized representative resides. The case management CSB is responsible for case management, liaison with the facility when an individual is admitted to a state facility, and discharge planning. If an individual, the parents of a minor receiving service, or legally authorized representative chooses to reside in a different locality after discharge from the facility, the community services board serving that locality becomes the case management CSB and works with the original case management CSB, the individual receiving services, and the state facility to effect a smooth transition and discharge. Reference in these protocols to CSB means Case Management CSB, unless the context clearly indicates otherwise.

Comprehensive Treatment Planning Meeting means the meeting, which follows the initial treatment meeting and occurs within seven (7) days of admission to a state mental health facility. At this meeting, the individual's Comprehensive Treatment Plan (CTP) is developed by the Treatment Team in consultation with the individual, the legally authorized representative, the CSB and with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct and support all treatment aspects for the individuals receiving services.

Discharge plan or **pre-discharge plan** hereafter referred to as the discharge plan means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.1-197.1 and § 16.1-346.1 of the *Code of Virginia* in consultation with the state mental health facility Treatment Team. This plan describes the community services and supports needed by the individual being served following an episode of hospitalization and identifies the providers of such services and supports. The discharge plan is required by § 37.1-197.1, § 16.1-346.1 and § 37.1-98 of the *Code of Virginia*. A completed or finalized discharge plan means the *Discharge Plan Form (DMH 1190C or DMH 1190)* on which all of the services to be received upon discharge are shown, the providers that have agreed to provide those services are identified, the frequency of those services is noted, and a specific date of discharge is entered.

Dual Diagnosis means an individual who has been clinically assessed as having <u>both</u> a serious mental illness and:

1. a diagnosis of mental retardation as defined in § 37.1-1 of the *Code of Virginia*, (the accepted acronym for this population is MI/MR) **OR,**
2. a co-occurring/co-existing substance abuse or addiction disorder, per criteria in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM), designated by the American Psychiatric Association.

Extended Rehabilitative Services means services provided for a period of 30 days or more after admission that offer intermediate or long term treatment in a state facility for individuals with severe psychiatric impairments, emotional disturbances, or multiple service needs (e.g. persons who are mentally ill and deaf).

Involuntary admission means an admission of an adult or minor that is ordered by a court through a civil procedure according to § 37.1-67.3 or § 16.1-346.1 of the *Code of Virginia.*

Legally Authorized Representative means a person permitted by law or regulations to give informed consent for disclosure of information and give informed consent to treatment on behalf of an individual who lacks the mental capacity to make such decisions.

Minor means an individual who is under the age of eighteen years.

Pre-admission screening means a face-to-face clinical assessment of an individual performed by a CSB to determine the individual's need for inpatient care and to identify the most appropriate and least restrictive alternative to meet the individual's need.

Primary substance abuser means an individual who is clinically assessed as having one or more substance abuse or dependence disorders per the current DSM; and the individual does not have an Axis I Mental Health disorder per the current DSM.

State Mental Health Facility or State Facility for purposes of these protocols, means a state mental health facility under the supervision and management of the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Treatment Team means the group of individuals that is responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services, a psychiatrist, a psychologist, a social worker, and a registered nurse. While not actual members of the facility Treatment Team, CSB staff shall actively participate, collaborate, and consult with the Treatment Team during the individual's period of hospitalization and is responsible for the preparation and, where appropriate, the implementation of the discharge plan.

Treatment Plans mean written plans that identify the individual's treatment, training, and service needs and stipulate the goals, objectives and interventions designed to address those needs. There are two sequential levels of Treatment Plans:

1. The "Initial Treatment Plan," which directs the course of care during the first hours and days after admission; and
2. The "Comprehensive Treatment Plan (CTP)," developed by the Treatment Team with CSB consultation, which guides, directs and supports all treatment of individuals receiving services.

Treatment Plan Review (TPR) means treatment planning meetings or conferences held subsequent to the Comprehensive Treatment Plan meeting.

I. Admission to State Facilities

	Facility Responsibilities	CSB Responsibilities
1.1		Section 37.1-197.1 of the *Code of Virginia* states that Community Services Boards (CSBs) are the single points of entry for publicly funded mental health, mental retardation, and substance abuse services**.** Section 37.1-67.1 of the *Code of Virginia* also stipulates that it is the responsibility of CSBs to perform a face-to-face pre-admission screening that confirms the appropriateness of admission to a state facility. **NOTE**: The *Code of Virginia* Sections 19.2-169.6, 19.2-176, 19.2-177.1 for Adults and Section 16.1-275 under the Juvenile provisions do not require NGRIs, Mandatory Parolees, or transfers from jail for treatment, evaluation or restoration to be prescreened by a CSB unless the individuals is being admitted for emergency treatment under a TDO pursuant to the above mentioned sections.
1.2	Upon admission, if the person is not able to make the necessary decisions (lacks the capacity to make an informed decision) regarding treatment and discharge planning and there are no family members available, state facility staff shall arrange for substitute consent as appropriate.	

	Facility Responsibilities	CSB Responsibilities
1.3	The state facility Treatment Team and Utilization Review Department, and, as appropriate the Forensic Coordinator, shall assess each individual upon admission and periodically thereafter to determine whether the state facility is an appropriate treatment site. These assessments shall be made available to the Case Management CSB for purposes of treatment and discharge planning. ***RECOMMENDED PRACTICES:*** 1. For individuals with the dual diagnosis of MR/MI, both the admitting Mental Health Facility and the region's Mental Retardation Training Center should confer to determine which institution can best serve the individual's needs. 2. If the individual with a dual diagnosis of MR/MI is sent to a State Mental Health Facility under a Temporary Detention Order (TDO), consultation prior to or participation at the commitment hearing is expected of: a. The Admitting Facility b. The Catchment Area's Training Center c. The Case Management CSB's Mental Health Services Staff d. The Case Management CSB's Mental Retardation Services Staff.	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in assessments to determine whether the state facility is an appropriate treatment site. ***RECOMMENDED PRACTICE:*** It should be the CSB's responsibility to notify its service area's state MH and MR facility of any known individual with the dual diagnosis of MR/MI who is receiving local inpatient services either through Temporary Detention Order, Civil Commitment or Voluntary Admission and who may require additional treatment in a state facility.
1.4	Facility staff shall contact the Case Management CSB by telephone within 24 hours of admission, or for weekends and holidays on the next working day, to notify the CSB of the new admission. In addition to contact by the Social Worker, Facility staff shall also fax a copy of the admissions face sheet, including the name and phone number of the Social Worker assigned and the name of the admitting ward, to the CSB within one (1) working day of admission. **NOTES**: 1. For all forensic admissions, Facility staff shall provide the CSB with a patient information sheet within one (1) working day of admission.	Upon notification of admission, CSB staff shall begin the discharge planning process. If the CSB disputes case management responsibility for the individual, the CSB shall notify the facility Social Worker immediately upon notification of admission. **NOTES**: 1. CSB staff is not responsible for completing the discharge planning forms for individuals admitted to a State Mental Health Facility and who are discharged prior to the CTP. However, CSB responsibilities post discharge will be reflected in the Discharge Instructions - Form 226. (Please see Attachment 3)

	Facility Responsibilities	CSB Responsibilities
1.4	2. Treatment Teams are not responsible for completing the Needs Upon Discharge Form for any individual admitted to a State Mental Health Facility and who is discharged prior to the CTP. However, the Treatment Team is responsible for completing the Discharge Instructions (Form 226). ***RECOMMENDED PRACTICE:*** When reporting admissions to the CSBs, facility staff should specify those individuals admitted to a state facility with a primary diagnosis of substance abuse.	2. For all forensic admissions, the CSB shall participate in the treatment and discharge process in accordance with these protocols. 3. For every admission to a State Mental Health Facility for individuals from the CSB's service area who are currently not served by that CSB, the CSB shall develop an open case and assign Case management responsibilities to the appropriate staff**.** (Please see SFY 2002 Community Services Performance Contract Section 5.3.5) ***RECOMMENDED PRACTICE:*** For each admission, the CSB should make every effort to establish a personal contact (face-to-face, telephone, etc.) at least weekly for acute admissions and at least monthly for those individuals receiving extended rehabilitative services.
1.5	The Treatment Team shall, to the greatest extent possible, accommodate the CSB when scheduling CTP and Treatment Plan Review (TPR) meetings. Facility staff shall inform the CSB of the date and time of the Comprehensive Treatment Plan (CTP) meeting at least 48 hours prior to the scheduled meeting. **NOTE**: The CTP meeting shall be held within seven (7) calendar days of the date of admission. ***RECOMMEDED PRACTICES:*** 1. Facilities should develop centralized scheduling for all CTP and TPR meetings. This process should be automated to allow for the posting of an e-mail calendar that would also provide advance notice for all treatment planning meetings. This e-mail calendar should be accessible to all the CSBs served by the facility. 2. Special consideration shall be made for scheduling and discharging individuals admitted with a primary substance abuse diagnosis, with attention focused on diversion efforts and other community alternatives.	CSB staff shall make arrangements to attend or otherwise participate in the CTP and TPR meetings. If the CSB staff is unable to physically attend the CTP or TPR meeting, it is CSB's responsibility to notify the Facility Social Worker and request arrangements for telephone or video conferencing accommodations. In the event that the above mentioned are not possible, it is the responsibility of the CSB staff to contact the Treatment Team or Facility Social Worker to discuss case specifics prior to receipt of the *Needs Upon Discharge Form.* **NOTES:** 1. While it may not be possible for the CSB to attend every treatment planning meeting, it is understood that attendance at treatment planning meetings is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. 2. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility. 3. For those individuals receiving extended rehabilitation services (those in a state

	Facility Responsibilities	CSB Responsibilities
1.5		facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual. 4. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.
1.6	The state facility in collaboration with CSB staff shall arrange for telephone and video conferencing accommodations for CSB staff, legally authorized representatives, and family members who are invited to attend meetings but are unable to attend in person.	

II. Needs Assessments & Discharge Planning

	Facility Responsibilities	CSB Responsibilities
2.1	The Treatment Team, with CSB consultation, shall ascertain, document and address the preferences of the individual or his legally authorized representative in the needs assessment and discharge planning process that will promote elements of recovery, self-determination and community integration.	
2.2	The Facility Social Worker shall complete a Psychosocial Assessment prior to the CTP for each individual receiving services. This assessment shall serve as one basis for determining the individual's needs upon discharge from the state facility. The Treatment Team shall document the individual's preferences in assessing the needs upon discharge from the state facility. Although the entire Treatment Team and CSB staff shall participate in evaluating the individual's needs, the Facility Social Worker (or designee) is responsible for documenting these needs on the *Needs Upon Discharge Form (DMH 1190F)* section of the Comprehensive Treatment Plan. (Please see Attachment 1) **NOTES:** 1. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established: a. That Facility staff has conducted a current psychological assessment. b. That Medicaid eligibility has been determined and confirmed.	CSB staff shall initiate discharge planning upon the individual's admission to a state facility. Discharge planning begins on the Initial Pre-Screening form and continues on the *Discharge Plan Form (DMH 1190C)* section of the CTP. (Please see Attachment 1). In completing the *Discharge Plan*, the CSB shall consult with members of the Treatment Team, the individual receiving services, his legally authorized representative, and, with his consent, family members or other parties in determining the preferences of the individual upon discharge. The Discharge Plan shall be developed in accordance with the *Code of Virginia* and the Community Services Performance Contract and shall: • include the anticipated date of discharge from the state facility; • identify the services needed for successful community placement; and • specify the public or private providers that have agreed to provide these services. **NOTES**: 1. For individuals with an MR/MI diagnosis, CSB Division Directors for Mental Health and Mental Retardation (or designees) shall conduct both case review and an assessment of the CTP to ensure intra-agency coordination. 2. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established: a. That a Level of Functioning (LOF) assessment has been completed by the CSB.

	Facility Responsibilities	CSB Responsibilities
2.2		b. That the Inventory for Client and Agency Planning (ICAP) has been completed. ***RECOMMENDED PRACTICE*:** For those individuals who are deaf, hard of hearing, late deafened, or deaf-blind, the CSB should coordinate the discharge planning effort with the Regional Deaf Coordinator.
2.3	The *Needs Upon Discharge* form shall be filled out as completely as possible by the Facility Social Worker (or designee) at the CTP meeting. If the CSB is not present at the CTP meeting, facility staff shall fax a copy of the *Needs Upon Discharge* form to the CSB within one (1) working day of the CTP meeting.	At the initial CTP meeting, CSB staff shall fill out as completely as possible the *Discharge Plan* section of the CTP and sign the CTP. If CSB staff is unable to attend the meeting, they shall send a copy of the *Discharge Plan* to the Facility Social Worker within three (3) working days of the initial CTP meeting (or receipt of the *Needs Upon Discharge Form*). The *Discharge Plan* must address each need identified on the *Needs Upon Discharge* section of the form.
2.4		The *Discharge Plan* cannot be filled out in the absence of the *Needs Upon Discharge* form. If the *Needs Upon Discharge* form is not available at the initial CTP meeting or within one (1) working day: • CSB staff shall notify the Treatment Team leader and Facility Social Worker. • If the *Needs Upon Discharge* form is not made available upon notification of the problem, the CSB staff shall notify the CSB Mental Health Director (or designee) who shall notify the Facility Social Work Director of the problem. • If the facility does not address the delinquencies, the CSB Executive Director shall contact the Facility Director in writing within two (2) working days of notification by the CSB Mental Health Director (or designee). • If completion of the *Needs Upon Discharge* form remains problematic, the CSB Executive Director shall notify the Assistant Commissioner for Facility Management in writing of the problem and include supporting documentation.

	Facility Responsibilities	CSB Responsibilities
2.5	The *Needs Upon Discharge* form shall be initiated at the first CTP meeting and updated at subsequent TPR meetings. As an individual's needs change, the Facility Social Worker shall document changes on the *Needs Upon Discharge* section of the CTP and in the Facility Social Worker's progress notes.	The *Discharge Plan* form shall be initiated at the first CTP meeting and updated at subsequent meetings. If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the Discharge Plan to address changes to the Needs Assessment. ***RECOMMENDED PRACTICE:*** Where applicable, CSB Mental Health, Mental Retardation and Substance Abuse staff should work jointly in the development and execution of the discharge plan.
2.6	In the event that a CSB fails to initiate the *Discharge Plan* form within three (3) working days of the initial CTP or receipt of the *Needs Upon Discharge Form* and other information from the state facility: • The Treatment Team Leader or designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the development or completion of the *Discharge Plan.* • If the CSB fails to initiate the *Discharge Plan* form upon notification of the problem, the Facility Social Work Director shall notify the CSB Mental Health Director (or designee) of the problem and document the contact in the individual's medical record. • If the CSB does not address the delinquencies, the Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team requesting a meeting with the Executive Director and Mental Health Director (or designee) in an effort to resolve the problems and issues associated with the development or completion of the *Discharge Plan.* • If the development or completion of the Discharge Plan by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioners of	

	Facility Responsibilities	CSB Responsibilities
2.6	Facility Management and of Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.	
2.7		As part of the individual's medical record, the CSB shall provide weekly discharge planning notes for individuals being treated on state facility admission wards. Discharge planning notes document the CSB's progress in discharging the individual. For those individuals being treated on other wards, discharge planning notes are required every 30 days. **NOTES:** 1. For those individuals found Not Guilty by Reason of Insanity (NGRI) who are being treated on civil wards, a discharge planning note is required weekly on admission wards and every 30 days on other wards. As the individual receives unescorted overnight community visits then discharge planning notes will be required every 14 days. 2. A CSB presence at the state mental health facility is not required for the completion of discharge planning notes. Discharge planning notes may be forwarded to the facility by secure e-mail, facsimile or mail.

III. Individualized Treatment Planning

	Facility Responsibilities	CSB Responsibilities
3.1	The Treatment Team, in consultation with CSB staff, shall develop an individualized treatment plan that is designed to lead to discharge. The Treatment Team shall, with the individual's and the CSB's input and recommendations, develop goals that will indicate the end of the treatment phase at the facility.	
3.2	Individuals receiving services**,** legally authorized representatives and, with the individual's consent, family members and private providers who will be involved in providing services shall be included in the treatment planning process and shall be asked to sign the treatment plan if present at treatment team meetings.	
3.3	The behaviors and skills that the individual will need to be successful in the designated discharge site shall drive treatment in a manner that will promote a successful discharge and avoid unnecessary readmission.	
3.4	With the individual's consent, facility staff, in collaboration with CSB staff, shall notify family members by telephone of dates and times of the Treatment Team meetings whenever possible.	
3.5	The Treatment Team, with CSB consultation, shall ascertain, document, and address the preferences of the individual or his legally authorized representative as to the placement upon discharge. **NOTE**: This may not be applicable for certain forensic admissions due to their legal status**.**	

IV. READINESS FOR DISCHARGE

	Facility Responsibilities	CSB Responsibilities
4.1	When the individual receiving services achieves the treatment goals identified in his CTP, the Treatment Team, with CSB consultation, may determine that the individual is clinically ready for discharge if the individual is medically stable and state facility level of care is no longer required or, for voluntary admissions, when consent has been withdrawn; and for **children and adolescents** any of the following: • The minor is unlikely to benefit from further acute inpatient psychiatric treatment; or • The minor has stabilized to the extent that inpatient psychiatric treatment in a state facility is no longer the least restrictive treatment intervention; or • If the minor is a voluntary admission, the legal guardian, or the minor if he is age 14 or older, has withdrawn consent for admission.	
4.2	Decisions regarding discharge readiness shall be made at CTP or TPR meetings. The CSB staff and the individual or his legally authorized representative shall be a part of the decision making process in determining whether or not the individual is ready for discharge The Treatment Team shall notify the Facility Director (or designee) when an individual is determined ready for discharge. If the CSB staff has not participated in the CTP or TPR meeting when an individual was determined to be ready for discharge, the Facility Social Worker is responsible for communicating decisions regarding discharge readiness to the CSB staff. The Facility Social Worker shall, by telephone contact the CSB within one (1) working day of the meeting and provide notification of readiness for discharge and document the call in the patient's medical record. This contact is to be followed by a written notification to the CSB. **NOTE:** The Facility Social Workers shall notify the Social Work Director or Forensic Coordinator and the CSB of any individual receiving forensic services who has been identified by the Treatment Team as clinically and legally ready for discharge to a correctional center or facility. ***RECOMMENDED PRACTICE*:** For those individuals being served on extended rehabilitation wards at state facilities, and for whom recovery is delayed due to the extent of their illness, the anticipated date of discharge should be assessed at least every 90 days.	

	Facility Responsibilities	CSB Responsibilities
4.3		If the CSB agrees that the individual is ready for discharge, it shall take immediate steps to finalize the *Discharge Plan* within no more than ten (10) working days. The individual shall be discharged from the facility as soon as possible but in no more than 30 calendar days of the notification except as provided for in Section 4.6, when the CSB experiences extraordinary barriers making it impossible to complete the discharge within 30 calendar days of notification. **NOTES:** 1. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility. 1. For those individuals receiving extended rehabilitation services (those in a state facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual. 3. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.

	Facility Responsibilities	CSB Responsibilities
4.4	State facility staff shall collaborate with CSB staff as needed in finalizing the *Discharge Plan.* **NOTE**: It is the sole responsibility of the CSB to make individual referrals to private providers, including Assisted Living Facilities (ALFs). The Case Management CSB may request that facility staff assist the referral process as needed. ***RECOMMENDED PRACTICE:*** For Acute Admissions, CSBs and Treatment Teams will accelerate the discharge process to shorten the time frames recommended and ensure continuity for existing community supports.	
4.5		After discharge, if the individual is not able to make the necessary decisions regarding treatment in the community, CSB staff shall arrange for substitute consent as appropriate. ***RECOMMENDED PRACTICE*:** Whenever possible, substitute consent needs to be in place by the date of discharge.
4.6		In the event the CSB experiences extraordinary barriers, including insufficiency of state funding and the lack of community infrastructure (including willing providers), making it impossible to complete the discharge within 30 calendar days of notification, the CSB must submit written notification to the Facility Director and the Commissioner of DMHMRSAS documenting why the discharge cannot occur within 30 days of notification. The documentation must describe the barriers to discharge and the specific steps being taken by the CSB to address them. This documentation shall be submitted no later than 30 calendar days from the notification of readiness for discharge. This shall be documented in the individual's Discharge Plan and the CSB discharge planning notes that are part of the individual's medical record.
4.7	Facility and CSB staff shall review on a monthly basis those cases that have been submitted to the Facility Director and the Commissioner of DMHMRSAS as impossible to discharge within 30 days and document the CSB's progress in addressing barriers to ensure that discharges are occurring at reasonable pace.	

	Facility Responsibilities	CSB Responsibilities
4.8	If the CSB agrees that the individual is ready for discharge but has neither completed nor implemented the discharge plan: • The Treatment Team Leader/Designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the CSB's completion of the *Discharge Plan.* • The Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team, and • If discharge efforts by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.	
4.9		If the CSB disagrees that the individual is clinically ready for discharge, the Executive Director shall notify the Facility Director and Treatment Team in writing within 10 working days of the notification of readiness for discharge. Also, the CSB staff must document the disagreement in the CSB discharge planning notes section of the patient's medical record within 30 calendar days of said notification.
4.10	When disagreements regarding readiness for discharge occur**,** the CSB and the state facility are expected to make a reasonable effort to resolve the disagreement before sending a written request for resolution to DMHMRSAS. This effort is to include at least one face-to-face meeting with state facility and CSB staff at a level higher than the Treatment Team with written documentation of the meeting's contents included in the individual's medical record.	
4.11	In the event that a resolution is not forthcoming, the party disagreeing with the individual's clinical readiness for discharge is responsible for initiating a request in writing to DMHMRSAS under the conditions specified in Attachment 5.3.4 of the Community Services Performance Contract.	

V. COMPLETING THE DISCHARGE PROCESS

	Facility Responsibilities	CSB Responsibilities
5.1	Facility staff in collaboration with CSB staff shall initiate applications for Medicaid, Medicare, SSI/SSDI and other financial entitlements (e.g., indigent medications). Applications shall be initiated in a timely manner prior to actual discharge when possible. For individuals receiving extended rehabilitation services at the facility, the application process shall begin not less than 30 days prior to the anticipated date of discharge. Each team member is responsible for timely and comprehensive reports as required for the applications. To facilitate follow-up, the Facility Social Worker shall notify the CSB of the date and type of entitlement application that is submitted. This will also be reflected in the *Needs Upon Discharge* section of the individual's *Discharge Plan*.	
5.2	The Treatment Team shall prepare the *Discharge Information and Instructions-Form #226* (Attachment 3) and obtain the physician's review and signature prior to discharge. At the actual time of discharge, facility staff shall review the *Discharge Information and Instructions* sheet with the individual or his legally authorized representative and request his signature. **NOTE**: Individual review of the *Discharge Information and Instructions* may not be applicable for certain forensic admissions due to their legal status. ***RECOMMENDED PRACTICE:*** A psychiatrist shall evaluate the patient and document the evaluation in 24 hours or less before the time of discharge.	To reduce re-admissions to state mental health facilities, CSBs shall develop, as appropriate and on an individual basis, a crisis intervention plan that is part of the final *Discharge Plan*. (See Attachment 2 for template design) **NOTES**: 1. Crisis plans are not required for individuals who have been acquitted as Not Guilty by Reason of Insanity (NGRI). 2. Similar documentation is included in the court documents and approved by the Forensic Review Panel. 3. Crisis Plans are not required for Court Ordered Evaluations, Restoration to Competency cases, and Jail Transfers. 4. For individuals with the dual diagnosis of MR/MI, an individualized behavior management or a crisis plan must be part of the *Discharge Plan*. These plans must work in conjunction with any pre-existing MR/MI protocols developed between the facility and it's service area. ***RECOMMENDED PRACTICES*:** 1. CSB staff should ensure that all arrangements for Psychiatric services and medical follow-up appointments are in place prior to discharge. 2. CSB staff should ensure the coordination of any other intra-agency services, e.g., employment, outpatient services, residential, etc.

	Facility Responsibilities	CSB Responsibilities
5.3	The Facility Medical Director shall be responsible for ensuring that the *Discharge Summary* is provided to the case management CSB within fourteen (14) calendar days of the actual discharge date.	
5.4		The CSB case manager, primary therapist, or other designated staff shall schedule an appointment to see individuals who have been discharged from a state mental health facility within seven (7) calendar days of discharge or sooner if the individual's condition warrants.
5.5		Individuals discharged from a state mental health facility who have missed their first appointment with the CSB case manager, primary therapist, psychiatrist, or day support program shall be contacted no later than 24 hours after the missed appointment. Written documentation shall be provided of efforts to see the person face-to-face no later than seven (7) calendar days after the missed appointment.
5.6		Individuals discharged from a state mental health facility with continuing psychotropic medications needs shall, to the extent practicable, be scheduled to be seen by the CSB psychiatrist within seven (7) calendar days post discharge, or sooner if the individual's condition warrants. In no case shall this initial appointment be scheduled longer than 14 calendar days following discharge.

VI. TRANSFER OF CASE MANAGEMENT CSB RESPONSIBILITIES

	Facility Responsibilities	CSB Responsibilities
6.1	The Facility Social Worker shall indicate in the progress notes any intention expressed by the individual receiving services or his legally authorized representative to change or transfer Case Management CSB responsibilities and the reason(s) for doing so. Prior to any further discussion with the individual, his legally authorized representative, family, or other parties, Facility Staff shall contact both the Case Management CSB and the CSB affected by the individual's intention to transfer so that they may begin discussion. This shall be documented in the individual's medical record.	Transfers shall occur when the individual receiving services or his legally authorized representative decides to relocate to another CSB service area. ***RECOMMENDED PRACTICE*:** Coordination of the possible transfer should allow for discussion of resources availability and resource allocation between the two CSBs prior to advancement of the transfer**.**
6.2		Transfer of Case Management CSB responsibility shall be handled according to DMHMRSAS policies and procedures as discussed in Section 4.5 of the *Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities.*
6.3		Exceptions to the above, shall be granted only when the CSB and individual receiving services or his legally authorized representative agree to keep services at the Case Management CSB while living in a different service area.
6.4	Facility Staff shall provide written notification to the current and new case management CSB at least 48 hours before the final TPR meeting. The Treatment Team shall to the greatest extent possible accommodate both CSBs when scheduling the final TPR meeting.	Case Management services must be provided by the new CSB promptly upon notification of transfer. This shall be effective no later than one week prior to the date of discharge. At a minimum, the new Case Management CSB shall attend the final Treatment Plan Review (TPR) meeting prior to the actual discharge date. The CSB of origin shall stay involved with the case for no less than 30 calendar days post discharge. The arrangements for and logistics of this involvement are to be documented in the *Discharge Plan*. **NOTE**: The criteria delineated in this section shall also apply to individuals with the dual diagnoses of MH/SA and MR/MI regardless of vendor, Medicaid Waiver eligibility or placement site.

	Facility Responsibilities	CSB Responsibilities
6.4		***RECOMMENDED PRACTICE*:** The CSB of origin should, upon notice of transfer, provide the new CSB with a copy of all relevant documentation related to the treatment of the individual.
6.5		If the two CSBs cannot agree on the transfer of case management responsibility before the individual is discharged, they shall seek resolution from the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance. The CSB of origin shall initiate this contact.